State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Shady Knoll Health Care Center
Address (No. & Street, City, State, Zip Code) 44 Skokorat Street Seymour, CT 06483
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning	Report for Year Ending
10/1/2015	9/30/2016

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2107C			07-5386

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2107C		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

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Shady Knoll Health Care Center	**2107C**	**9/30/2016**	**1**	**37**

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for **Shady Knoll Health Care Center** [facility name] for the cost report period beginning **October 01, 2015** and ending **September 30, 2016**, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under penalities of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
		2/15/17		2/15/17
Printed Name (Administrator) Deborah S.Torrey			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of Conn	Date 2/15/17	Signed (Notary Public)	Comm. Expires 3/31/20
Address of Notary Public			11 Terrace Ln Bristol CT 0600	

(Notary Seal)

MYERS AND STAUFFER LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

7 Waterside Crossing, Ste 202 | Windsor, CT 06095
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810
www.mslc.com

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State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility **Shady Knoll Health Care Center**	Period Covered:		From **10/1/2015**	To **9/30/2016**
Address of Facility **44 Skokorat Street Seymour, CT 06483**				
Report Prepared By **Athena Health Care Associates, Inc**	Phone Number **(860) 751-3900**		Date **2/15/2017**	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid..... $				
2. Laundry wages paid..... $				
3. Housekeeping wages paid..... $				
4. Nursing wages paid..... $				
5. All other wages paid..... $				
6. ***Total Wages Paid***..... $				
7. Total salaries paid..... $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-881-2555	**09/30/16**	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Shady Knoll Health Care Center	**44 Skokorat Street Seymour, CT 06483**

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2107C			**07-5386**

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

☐ PROPRIETORSHIP ☐ LLC ☐ PARTNERSHIP ☑ PROFIT CORP. ☐ NON-PROFIT CORP. ☐ GOVERNMENT ☐ TRUST

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ☐ Yes ☑ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Deborah S.Torrey	**001800**

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
Not Applicable			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Shady Knoll Health Center, Inc.	**41 Skokorat St, Seymour, CT 06483**	**CT**

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	**41 Skokorat St, Seymour, CT 06483**	**President**	**5602.02**
Debra M Soucey	**41 Skokorat St, Seymour, CT 06483**	**Secretary**	
Michael E. Mosier	**41 Skokorat St, Seymour, CT 06483**	**Treasurer**	
Names of Stockholders Owning at Least 10% of Shares			
Custodians for Lawrence E. Santilli	**41 Skokorat St, Seymour, CT 06483**		**2397.98**

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General Information and Questionnaire
Individual Proprietorship

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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

Not Applicable

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ☐ Yes ☑ No — If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ☑ Yes ☐ No — If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Laurel Ridge Health Care Center	**642 Danbury Road Ridgefield, CT 06877**	☑	☐	**>98%**	**Bank Fees**	**Pg 16 ln m13**	**$7,717**	**$7,717**
Athena 401 (K) Plan	**135 South Road, Farmington, CT 06032**	☐	☑		**Facility Participates in a Multi Facility 401(K) Plan**			
Athena Captive	**135 South Road, Farmington, CT 06032**	☐	☑		**Workers Comp Captive**	**Pg 15 ln a1**	**$398,270**	**$398,270**
Shady Knoll Landlord	**135 South Road, Farmington, CT 06032**	☐	☑		**Lease of Facility**	**Pg 22, ln 9, 10b; Pg 27 ln 14**	**$788,256**	**$788,256**
Misc. Facilities	**Various**	☑	☐	**>98%**	**Interfacility Loans**	**Pg 33, Ln A2**		
Litchfield Woods Health Care	**255 Roberts St, Torrington, CT 06790**	☑	☐	**>98%**	**Legal Fees, LOC Fees**	**Pg 15 Ln 1e, Pg 34 B 3**	**$26,910**	**$26,910**
		☐	☐					
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**>50%**	**See Attached**			
Athena Health Insurance	**135 South Road, Farmington, CT 06032**	☑	☐	**>50%**	**Self Insured Employee Health & Dental Insurance**	**Pg 15, Ln 1a5**	**$1,025,242**	**$1,025,242**

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

Shady Knoll Health Care Center
RELATED PARTIES QUESTIONNAIRE
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care	135 South Road Farmington, CT	X		>50%	Insurance Office Supplies, Health Insurance Employee Relations, Other Advertising, Lobbying Payroll Service Fees, Data Processing Fees, Repairs & Maintenance, Management Fees	Pg 15 1a1 Pg 15 ln 1a5, 1g Pg 16 ln l3 Pg 16 ln m3, m13 Pg 22 ln 6a, Pg 32 ln C5, Pg 17	$680,491	$293,404
Bayview Health Care Center	301 Rope Ferry Rd Waterford, CT 06385	X		>98%	Data Processing Fees	Pg 16 M13	$1,511	$1,511
Procare LTC Pharmacy	111 Executive Blvd Farmingdale, NY 11735	X		>50%	Pharmacy Services	Pg 13 & Pg 20	$104,076	$104,076

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General Information and Questionnaire
Basis for Allocation of Costs

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ☑ Yes ☐ No If "No," explain fully why such allocation was not made.

Not Applicable

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

Not Applicable

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

☐ Yes ☐ No If "No," explain fully why such allocation was not made.

Not Applicable:No Non-Nursing Home Cost Centers

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General Information and Questionnaire
Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	☐	☑	**Postal Equipment**	**04/01/14**	**Automatic Renewal**	**$3,308**	**$3,308**
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	☐	☑	**Copier**	**06/19/13**	**33 Months**	**$2,808**	**$2,808**
Graphic Savings group, 457 Castle Ave, Fairfield, CT 06825	☐	☑	**copier**	**03/01/12**	**48 Months**	**$8,244**	**$8,244**
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	☐	☑	**copier**	**02/07/12**	**48 months**	**$840**	**$840**
HP Financial Services, 200 Connell Dr, Suite 5000, Berkeley Heights, NJ 07922	☐	☑	**PCC Equipment**	**08/16/13**	**60 months**	**$6,584**	**$6,584**
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	☐	☑	**Copier**	**02/22/16**	**48 Months**	**$11,503**	**$7,668**
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ No **Total ***** $29,452

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

LEAF

LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

LESSEE LEGAL NAME:	Tax ID#:	Telephone No:
Shady Knoll Health Center, Inc.	061315696	2038812555

Billing Address:	Equipment Location (if other than Billing Address):
41Skokorat Street, Seymour, CT 06483	41 Skokorat Street, Seymour, CT 06483

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments – see below and/or attached Schedule A)

Unit Quantity	Description of Equipment Leased	Make and Type	Model Number	Serial Number
	* PLEASE REFER TO SCHEDULE A			

BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS	END OF LEASE PURCHASE OPTION		
48	48 @ $901.32 (plus taxes)	X Fair market value, plus taxes ___ 10% of Equipment cost, plus taxes ___ $1.00, plus taxes (FMV unless another option is selected. You may not exercise a purchase option if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without warranty.)	(a) Advance Payment:	$0.00
			(b) Security Deposit:	$0.00
			(c) Documentation Fee:	$95.00
			Total due a+b+c=:	$95.00

**If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment.
Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.

TERMS AND CONDITIONS

In this agreement ("Lease"), "we," "our," and "us" refers to **LEAF Capital Funding, LLC** as Lessor and "you" and "your" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

1. LEASE PAYMENTS AND TERM: The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you ("Lease Commencement Date"). The first Lease Payment shall be due on the date we specify in the month following the Lease Commencement Date as set forth in our invoice, and the remaining Lease Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Lease Payment for the period from the Lease Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Lease Payments up to 15% if the actual costs are different than the estimate used to calculate the Lease Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. Unless you notify us otherwise in writing within 10 days of delivery, you unconditionally accept the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. **You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair.** We are not responsible for Equipment or vendor failures.

3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment.

4. LEASE EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Lease of your election to return or purchase the Equipment, this Lease will renew on a month-to-month basis at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Lease Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling. If you exercise a purchase option we will convey all of our interest in such Equipment to you on an AS-IS WHERE IS basis without representation or warranty.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each pay by phone and $35 for each returned payment.

6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. **WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.**

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of such insurance and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. For administrative purposes, unless we otherwise direct in writing, you will list Lessee as the owner of the Equipment for property tax purposes and file and pay when due any property taxes relating to the Equipment directly to the taxing authority and provide us with evidence of compliance. If we pay any taxes, fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Lease Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Lease for you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

11. ARTICLE 2A: You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. **You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC.** You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

14. MISCELLANEOUS: This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. A fax of the Lease with fax signatures may be treated as an original and will be admissible as evidence. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY LESSEE: Shady Knoll Health Center, Inc.

X _____
Lessee Authorized Signature

Print Name: DEBORAH S. TORREY Title: ADMINISTRATOR

E-Mail Address: administrator@shadyknollhc.com Date: 2/18/16

PERSONAL GUARANTY: Undersigned guarantees that Lessee will make all payments and perform all other obligations under the Lease when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Lessee or the Equipment. Undersigned also waives all suretyship defenses and notification if the Lessee is in default and consents to any extensions or modifications granted to Lessee. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Lessee. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X _____ Print Name: _____ E-Mail Address: _____

Accepted by:
LEAF Capital Funding, LLC By: _____ Title: Operations Manager Date: 2/22/2016

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	**7**	**37**

The records of this facility for the period covered by this report were maintained on the following basis:

☑ Accrual ☐ Cash ☐ Modified Cash

Is the accounting basis for this period the same as for the previous period? ☑ Yes ☐ No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 **Marcum LLP**	**555 Long Wharf Dr, 12th Floor, New Haven, CT 06511**
2 **Dworken, Hillman, Lamorte & Sterczala**	**4 Corporate Drive, Suite 488, Shelton, CT 06484**
3 **Dopkins & Company, LLP**	**200 International Dr, Buffalo, NY 14221**
4	

Services Provided by This Firm (*describe fully*)

1	**2015 Medicare Cost Report**	**$ 2,650**
2	**2016 Audit, Year End Financials & Tax Return $14,000**	**$ 14,000**
3	**KeyBank Audit: Disallowed**	**$ 3,706**
4		**$ -**

Charge for Services Provided **$20,356**

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

☑ Yes ☐ No **Pg 15, Line1d**

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 **Schiff Hardin LLP**	**312-258-5500**
2 **Murtha Cullina, LLP**	**860-240-6000**
3 **Probate**	
4 **Goldman Gruder & Woods**	**203-899-8900**
5	

Address (*No. & Street, City, State, Zip Code*)

1 **6600 Sears Tower, Chicago, IL 60606-6473**
2 **185 Asylum St, Hartford, CT 06103**
3
4 **200 Connecticut Ave, Norwalk, CT 06854**
5

Services Provided by This Firm (*describe fully*)

1	**Revolving Credit Agreement:Disallow**	**$ 2,685**
2	**Prep Secretary of State Annual Reports and Audit Letter $820: Allowed; General Matters $268 Disallow**	**$ 1,088**
3	**Collections: Disallow**	**$ 290**
4	**Collections: Disallow**	**$ 32,905**
5		**$ -**

Charge for Services Provided **$36,968**

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

☑ Yes ☐ No **Pg 15, Line 1e**

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period.....	128	128			128	128			128	128		
B. On last day of THIS report period.....	128	128			128	128			128	128		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	120	120			124	124			120	120		
B. As of midnight of THIS report period.....	124	124			127	127			124	124		
3. Total Number of Days Care Provided During Period												
A. Medicare.....	6,076	6,076			4,574	4,574			1,502	1,502		
B. Medicaid (Conn.).....	34,377	34,377			25,977	25,977			8,400	8,400		
C. Medicaid (other states).....												
D. Private Pay.....	3,406	3,406			2,512	2,512			894	894		
E. State SSI for RCH.....												
F. Other (Specify) Managed Care	1,775	1,775			1,141	1,141			634	634		
G. Total Care Days During Period (3A thru F).....	45,634	45,634			34,204	34,204			11,430	11,430		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days.....	259	259			163	163			96	96		
B. Other Bed Reserve Days.....	187	187			144	144			43	43		
5. ***Total Resident Days*** **(3G + 4A + 4B).....**	46,080	46,080			34,511	34,511			11,569	11,569		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ☐ YES ☑ NO
If "YES", provide the following information:

Date of Change	Place of Change CCNH (1)	RHNS (2)	(Specify) (3)	Change in Beds Lost (1)	(2)	(3)	Gained (1)	(2)	(3)	Capacity After Change CCNH	RHNS	(Specify)	Reason for Change

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	10	94		8		12		
Per Diem Rate								
a. One bed rm.	523.05	232.73		501.00		350.80		
b. Two bed rms.	523.05	232.73		491.00		350.80		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	5,955	5,955		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,099	1,099		
2. Restorative Treatments				
C. Other	15,789	15,789		
D. ***Total Physical Therapy Treatments***	22,843	22,843		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,118	1,118		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	82	82		
2. Restorative Treatments				
C. Other	2,144	2,144		
D. ***Total Speech Therapy Treatments***	3,344	3,344		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	8,839	8,839		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	647	647		
2. Restorative Treatments				
C. Other	14,538	14,538		
D. ***Total Occupational Therapy Treatments***	24,024	24,024		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ☑ Yes ☐ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	107,289	2,085				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	248,108	10,856				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	68,588	2,081				
c. Dietary Workers	409,136	28,110				
6. Housekeeping Service						
a. Head Housekeeper	58,844	2,498				
b. Other Housekeeping Workers	200,622	15,287				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	64,810	2,213				
b. Other Maintenance Workers	58,658	3,130				
8. Laundry Service						
a. Supervisor	8,949	442				
b. Other Laundry Workers	120,709	7,874				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	185,855	4,027				
b. RN						
1. Direct Care	451,082	11,648				
2. Administrative**	539,008	19,330				
c. LPN						
1. Direct Care	1,103,014	42,753				
2. Administrative**						
d. Aides and Attendants	1,730,903	117,444				
e. Physical Therapists	637,976	18,502				
f. Speech Therapists	136,228	2,752				
g. Occupational Therapists	388,878	10,522				
h. Recreation Workers	144,287	7,653				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	187,924	7,560				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	6,850,868	316,767				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Total	$ -	-	$ -	-	$ -	-

Schedule of Physician: Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Total	$ -	-	$ -	-	$ -	-

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not Applicable										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** employment worked during the cost year.

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Deborah S. Torrey (10/1/15-9/30/16)	107,289			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,085	A2			
Section IV - Assistant Administrators										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	10,762	300				
2. Dentist	12,864	47				
3. Pharmacist	11,093	171				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	158				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	15,606					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	2,880	8				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	113,205	684				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

*** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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B. Report of Expenditures - Professional Fees (Medical Director Detail)

Name of Facility	License No.	Report for Year Ended	Page	of
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			Total Cost and Hours					
	Item		CCNH	Hours	RHNS	Hours	(Specify)	Hours
8.	Physicians							
a.	Medical Director Detail		0	158	0	0	0	0

Dr Garumuni Desilva	$48,000	59 hours
Dr Hafsa Nawaz	$12,000	99 hours

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Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Healthdrive Audiology, 888 Worcester St, Wellesley, MA 02482	Physician Services	☐	☑	
Healthdrive Podiatry, 888 Worcester St, Wellesley, MA 02482	Physician Services	☐	☑	
CT Dental, 240 Pomeroy Ave, Suite 2015, Meriden, CT 06450	Dentist	☐	☑	
Omnicare of Connecticut, 525 Knotter Drive, Cheshire, CT 06410	Pharmacist	☐	☑	
Margaret Holden, 255 Cooper Pl. New Haven, CT 06511	Dietician	☐	☑	
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	☑	☐	Common Owners
Yale New Haven Hospital, PO Box 1403, New Haven, CT 06505	Physician Services	☐	☑	
Healthdrive Medical & Dental Practices, 1 Prestige Dr, Meriden, CT 06450	Dentist	☐	☑	
Healthdrive Eye Care Group, 888 Worcester St, Wellesley, MA 02482	Physician Services	☐	☑	
Valley Orthopaedic, 2 Trap Falls Rd, Suite 404, Shelton, CT 06484	Physician Services	☐	☑	
Dr. Hafsa Nawaz, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven, CT	Asst. Medical Director	☐	☑	
Griffin Hospital, 130 Division St, Derby, CT 06418	Physician Services	☐	☑	
Pact LLC, 322 East Maine St, Suite 1B, Branford, CT 06405	Physician Services	☐	☑	
Garumuni Desilva, MD, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven,	Medical Director	☐	☑	
SDX Swallowing Diagnostics, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	☐	☑	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	$	398,270	398,270		
2. Disability Insurance.....	$				
3. Unemployment Insurance.....	$	148,319	148,319		
4. Social Security (F.I.C.A.).....	$	523,870	523,870		
5. Health Insurance.....	$	1,025,242	1,025,242		
6. Life Insurance (employees only)					
(not-owners and not-operators).....	$				
7. Pensions (Non-Discriminatory)	$	40,627	40,627		
(not-owners and not-operators).....					
8. Uniform Allowance.....	$				
9. Other (*Specify*).....	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*.....	$	52,446	52,446		
d. Accounting and Auditing.....	$	20,356	20,356		
e. Legal (*Services should be fully described on Page 7)*	$	36,968	36,968		
f. Insurance on Lives of Owners and Operators (*Specify*)*.....	$				
g. Office Supplies.....	$	52,220	52,220		
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	$	34,827	34,827		
2. Cellular Phones.....	$	3,140	3,140		
i. Appraisal (*Specify purpose and attach copy*)*.....	$				
j. Corporation Business Taxes (*franchise tax*).	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*.....	$	250	250		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	839,497	839,497		
Subtotal	$	3,176,032	3,176,032		

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	$ -	$ -	$ -

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C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,176,032	3,176,032		
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	$				
2. Holiday Parties for Staff.....	$	7,616	7,616		
3. Gifts to Staff and Residents.....	$	14,537	14,537		
4. Employee Travel.....	$	8,842	8,842		
5. Education Expenses Related to Seminars and Conventions	$	3,674	3,674		
6. Automobile Expense (*not purchase or depreciation*).....	$				
7. Other (*Specify*).....	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*).....	$	5,200	5,200		
2. Advertising Telephone Directory (*all such expenses*)***	$	202	202		
3. Advertising Other (*Specify*)***.....	$	30,910	30,910		
See Attached Schedule					
4. Fund-Raising***.....	$				
5. Medical Records.....	$	(66)	(66)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	$				
7. Postage.....	$	7,189	7,189		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,297	9,297		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	1,300	1,300		
9. Subscriptions.....	$	224	224		
10. Contributions*** See Attached Schedule	$	60	60		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**.....	$	427,255	427,255		
13. Other (*Specify*) See Attached Schedule	$	91,536	91,536		
C-14 Total Administrative & General Expenditures	$	3,783,808	3,783,808		

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 30,910		
Total Other Advertising	$ 30,910	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
AANAC	$ 229		
CAHCF	$ 9,068		
Total Dues	$ 9,297	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	$ 60		
Total Contributions	$ 60	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	$ 4,287		
Data Processing Fees	$ 19,294		
Bank Charges	$ 8,299		
Payroll Processing Fees	$ 25,314		
Employee Physicals	$ 18,044		
Compliance Consulting	$ 9,170		
Penalty-State of CT Citation #2016-31	$ 1,635		
Penalty-CMS Citation #075386	$ 1,170		
Utility Audit	$ 312		
Medicaid Application	$ 2,500		
JDA Settlement-Bayview	$ 1,511		
Total Other Administrative and General	$ 91,536	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$592,192	Contract Attached to a Prior Year	See Below
Allocation of the above	$390,847 $94,751 $106,595	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$36,408	Admin/Gen - Other Exp	Pg 16, Line 12

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	$	283,064	283,064		
2. Non-Food Supplies.....	$	34,827	34,827		
3. Other (*Specify*)_____	$	189	189		
Dishes = $189					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$	94,751	94,751		
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	412,831	412,831		

		Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*	374	374		

H.	Is cost of employee meals included in 2E?	☑	Yes	☐	No	
I.	Did you receive revenue from employees?	☐	Yes	☑	No	If yes, specify amount.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	☑	Yes	☐	No	If yes, specify cost. = $1868
L.	Is any revenue collected from these people?	☑	Yes	☐	No	If yes, specify amount. = $758
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					**Pg 18 ln 2a1**
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	☐	Yes	☑	No	If yes, specify cost.
O.	Is any revenue collected from employees?	☐	Yes	☑	No	If yes, specify amount.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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C. Expenditures Other Than Salaries (cont'd) Laundry-Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	12,057	12,057		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$				
d. Other (*Specify*) **Supplies = $8,909; = $305**	$	9,214	9,214		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	21,271	21,271		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	☐ Yes	☑ No	If yes, specify cost.
H.	Did you receive revenue from employees?	☐ Yes	☑ No	If yes, specify amount.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	☐ Yes	☑ No	If yes, specify cost.
K.	Did you receive revenue from these people?	☐ Yes	☑ No	If yes, specify amount.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Pounds of Laundry only required for multi-level facilities.

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C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page	of
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Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	33,567	33,567		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
c. Management Services*.....		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)...		$	33,567	33,567		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....		$				
2. Purchased from **Omni Care/Procare**		$	308,892	308,892		
b. Medicine Cabinet Drugs.....		$	9,855	9,855		
c. Medical and Therapeutic Supplies.....		$	265,931	265,931		
d. Ambulance/Limousine***.....		$	1,181	1,181		
e. Oxygen						
1. For Emergency Use.....		$				
2. Other***.....		$	36,217	36,217		
f. X-rays and Related Radiological Procedures***.....		$	33,543	33,543		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***.....		$	46,362	46,362		
i. Recreation.....		$	25,526	25,526		
j. Other (Specify)**** See Attached Schedule		$	209,981	209,981		
5K. ***Total Resident Care Expenditures*** (5a - 5j).....		$	937,488	937,488		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	**CCNH**	**RHNS**	**(Specify)**
Management Fee Direct	$ 106,595		
Physical Therapy Supplies	$ 35,071		
Medical Equipment Rental-Other	$ 31,095		
Cable TV Services	$ 11,367		
Oxygen equipment rentals	$ 19,053		
Medical Equipment Rental-Medicaid	$ 6,800		
Total Other Resident Care	$ 209,981	$ -	$ -

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Report of Expenditures
Schedule C-2 - Individuals or Firms Providing Services by Contract *

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	☐	☑		Payroll Processing	20,812			16	m13
Ct Waste Processing	PO Box 99, Plainville, CT 06062	☐	☑		Rubbish Removal	28,636			22	6f
Oxford Landscaping	241 Oxford Rd, Oxford, CT 06478	☐	☑		Groundskeeping/Snow Removal	13,087			22	6f
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	☑	☐	Common Owners	Pharmacy	104,076			20	5a2
Value/Omnicare	525 Knotter Drive, Cheshire, CT 06410	☐	☑		Pharmacy	186,855			20	5a2
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility	License No.	Report for Year Ended			Page of
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Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	108,419	108,419		
b. Heat	$	38,835	38,835		
c. Light & Power	$	134,678	134,678		
d. Water	$	61,226	61,226		
e. Equipment Lease (*Provide detail on page 6*)	$	29,452	29,452		
f. Other (*itemize*)	$	71,994	71,994		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	444,604	444,604		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	5,947	5,947		
b. Building & Building Improvements	$	97,646	97,646		
c. Non-Movable Equipment	$	35,493	35,493		
d. Movable Equipment	$	69,585	69,585		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	208,671	208,671		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	3,980	3,980		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	3,980	3,980		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	557,650	557,650		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	145,248	145,248		
c. Personal property taxes	$	12,257	12,257		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	927,806	927,806		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

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Schedule of Other Repairs and Maintenance

Description	**CCNH**	**RHNS**	**(Specify)**
Groundskeeping	$ 12,013		
Rubbish Removal	$ 28,636		
Snow Removal	$ 4,122		
Supplies	$ 27,223		
Total Other Repairs and Maintenance	$ 71,994	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	70,380		70,380	53,071	SL	Var	5,947	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								5,947
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,747,855		2,747,855	1,724,200	SL	Var	97,646	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								97,646
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	630,911		630,911	198,337	SL	Var	35,493	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								35,493

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2015	867,350		867,350	666,868	S/L	Var	65,915	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2016	50,132		50,132		S/L	Var	3,670	
D-3. Subtotal												69,585
E. ***Total Depreciation***												208,671

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Nov-15	Kittredge-ice maker	$ 5,751	10	$ 288	
Nov-15	precision seating-pressure mapping device	$ 2,814	5	$ 281	
Jan-16	write way signs-signs	$ 7,512	10	$ 376	
Jan-16	joerns-hoyer lift	$ 2,941	10	$ 147	
Jan-16	triple a supplies-autoscrubber	$ 4,606	5	$ 461	
Feb-16	daniel's equipment-dryer burners & burner box	$ 1,094	10	$ 55	
Feb-16	joerns-hoyer lift	$ 3,551	10	$ 178	
Feb-16	proline-oven blower motor	$ 1,225	10	$ 61	
Mar-16	daniel's equipment-washing machine motor	$ 1,518	5	$ 152	
Mar-16	daniel's equipment-dryer blower motor	$ 1,883	5	$ 188	
Mar-16	daniel's equipment-dryer blower wheel credit	$ (330)	5	$ (33)	
Apr-16	daniel's equipment-rebuild washing machine	$ 5,047	5	$ 505	
Apr-16	modern mechanical-heat pump laundry	$ 1,650	10	$ 83	
Jun-16	kittredge-garbage disposal	$ 1,833	5	$ 183	
Jun-16	aquarion water-rebuild washing machine-back	$ 1,337	5	$ 134	
Jun-16	aquarion water-rebuild washing machine-back	$ 1,127	5	$ 113	
Jul-16	cal business-binary	$ 904	3	$ 151	
Sep-16	alimed-adjustable parallel bars	$ 4,005	10	$ 200	
Sep-16	cdw-laptop	$ 568	3	$ 95	
Sep-16	joerns-trapeze attachment	$ 1,096	10	$ 55	
Total additions for Movable Equipment		$ 50,132		$ 3,670	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**

****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Jan-16	fire services group-sprinkler repair	$ 2,982	15	$ 99	
Apr-16	all trade industries-2 fire doors	$ 3,674	15	$ 122	
May-16	fire services group-sprinkler repair	$ 2,001	15	$ 67	
Total additions for Leasehold Improvements		$ 8,657		$ 289	*
Deletions:					
Total deletions for Leasehold Improvements		$ -		$ -	**

***Ties to Page 24, Line C3**

****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. **Finance Fees-Key Bank**	6	2007	7 years	305,597	305,597	SL	0		
2. **Finance Fees**									
3. **Finance Fees**									
B-4. Subtotal									
C. **Leasehold Improvements and Other** (Specify)									
1. Acquired prior to this report period		2015	Various	1,133,348	374,158	53,348	Var	3,691	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2016	Various	8,657		10,994	Var	289	
C-4. Subtotal									3,980
D. ***Total Amortization***									3,980

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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Supplemental Page

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility			License No.		Report for Year Ended			Page	of
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C. **Leasehold Improvements** (Specify)									
1. Acquired prior to this report period		2015		53,348	5,347	53,348	Variou	3,691	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2016	Various	8,657		10,994	Variou	289	
C-4. Subtotal.....									3,980
C. **Other** (Specify)									
1. Bed License Purchase	9	1997	30 yrs	1,080,000	368,811	SL	0		
2.									
C-4. Subtotal.....									
Total Acquired prior to this report period		2015	Various	1,133,348	374,158	53,348	Var	3,691	
Total Disposals									
Total Acquired during this report period	9	2016	Various	8,657		10,994	Var	289	

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C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

Name of Facility	License No.	Report for Year Ended	Page of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party*? ☑ Yes ☐ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	1991
2. Date Structure Completed	5/21/1993
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	05/21/93
5. Total Licensed Bed Capacity	128
6. Square Footage	
7. Acquisition Cost	
a. Land	652,528
b. Building	5,696,463

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	31			
e. Amount of Principal Borrowed	10,237,067			
f. Principal balance outstanding as of 9/30/2016	7,194,326			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility	License No.	Report for Year Ended	Page of
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Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage..... $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage..... $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage..... $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage..... $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount..... $				
2. Loan Origination Date.....				
3. Interest Rate %.....				
4. Term.....				
5. CHEFA Interest Expense.....				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(Carry Subtotals forward to next page)

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C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment..... $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*)..... $	15,155	15,155		
A. Item / Rate / Amount				
Boiler Capital Lease / **6.04%** / **390,250**				
Lender				
Graybar Financial Services				
Address of Lender				
PO Box 644006, Cincinnati, OH 45264				
B. Item / Rate / Amount				
-				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)..... $	15,155	15,155		
12. D. Other Interest Expense (*Specify*)..... $	186,906	186,906		
Vender Interest = $2,564; Key Bank Line of Credit Interest = $115,885; Key Bank Term Loan Int & Fees = $68,457				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D).....$	202,061	202,061		
14. Insurance				
a. Insurance on Property (buildings only)..... $	87,650	87,650		
b. Insurance on Automobiles..... $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*)..... $				
2. Fire and Extended Coverage..... $				
3. Other (*Specify*)..... $				
14d. ***Total Insurance Expenditures*** (14a + b + c)... $	87,650	87,650		
15. ***Total All Expenditures (A-13 thru C-14)*****.....** $	13,815,159	13,815,159		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs..... $				
2.			Salaries not related to Resident Care.... $				
3.	10	A12g	Occupational Therapy..... $	388,878	388,878		
4.	Var	Var	Other - See attached Schedule..... $	30,385	30,385		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **..... $	15,606	15,606		
6.			Occupational Therapy..... $				
7.			Other - See attached Schedule..... $				
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits..... $				
9.	15	1c	Bad Debts..... $	52,446	52,446		
10.	15	1d&e	Accounting & Legal..... $	39,854	39,854		
11.	30	IV3	Telephone..... $				
12.	15	1h2	Cellular Telephone..... $	1,700	1,700		
13.			Life insurance premiums on the life of Owners, Partners, Operators..... $				
14.	16	l3	Gifts, flowers and coffee shops..... $	14,537	14,537		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees..... $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative.... $				
17.			Automobile Expense (e.g. personal use). $				
18.	16	m2&3	Unallowable Advertising *..... $	31,112	31,112		
19.	15	1j&k1 &2	Income Tax / Corporate Business Tax... $	250	250		
20.	16	m4&10	Fund Raising / Contributions..... $	60	60		
21.	16	m12	Unallowable Management Fees..... $	255,477	255,477		
	18	2c	$	61,934	61,934		
	20	5j	$	69,676	69,676		
22.	16	m6	Barber and Beauty..... $				
23.	Var	Var	Other - See attached Schedule..... $	29,872	29,872		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents..... $	1,868	1,868		
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents..... $				
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents..... $				
			Subtotal (Items 1 - 26) $	993,655	993,655		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing Salaries & Benefits	2,738		
10	12m	Community Liason Salary & Benefits	27,647		
Total Other Salaries Adjustment			$ 30,385	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8n	Disallowed Dues	1,300		
16	M13	Bank Charges	8,299		
16	M13	Lobbying Fees	4,287		
16	M13	Compliance Consulting	9,170		
16	M13	Penalty: State of CT Citation No. 2016-31	1,635		
16	M13	Penalty: CMS Citation #075386	1,170		
16	M13	Medicaid Application	2,500		
16	m13	JDA Settlement-Bayview	1,511		
Total Other A&G Adjustments			$ 29,872	$ -	$ -

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D. Adjustments to Statement of Expenditures (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	993,655	993,655		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs..... $	308,892	308,892		
28.	20	5d	Ambulance/Limousine..... $	1,181	1,181		
29.	20	5f	X-rays, etc..... $	33,543	33,543		
30.	20	5h	Laboratory..... $	46,362	46,362		
31.	20	5c	Medical Supplies..... $	18,380	18,380		
32.	20	5e2	Oxygen (non emergency)..... $	36,217	36,217		
33.			Occupational Therapy..... $				
34.	Var	Var	Other - See Attached Schedule..... $	31,095	31,095		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule..... $	12,874	12,874		
36.			Depreciation on Unallowable Motor Vehicles..... $				
37.			Unallowable Property and Real Estate Taxes..... $				
38.			Rental of Building Space or Rooms..... $				
39.			Other - See Attached Schedule..... $				
Page 27 - Insurance							
40.			Mortgage Insurance..... $				
41.			Property Insurance..... $				
Other - Miscellaneous							
42.			Research or Experimental Activities..... $				
43.	20	5j	Radio and Television Revenue..... $	7,767	7,767		
44.			Vending Machine Revenue..... $				
45.			Purchase Discounts and Allowances.... $				
46.			Duplications of functions or services.... $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest..... $				
48.	30	IV5	Interest Income on Accounts Rec..... $	174	174		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule..... $				
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule..... $				
51.	***Total Amount of Decrease (Items 1 - 50)*** ..... $			1,490,140	1,490,140		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	31,095		
Total Other Ancillary Costs			$ 31,095	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	12,874		
Total Excess Movable Equipment Depreciation			12,874		

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments					

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Shady Knoll Moveable Equipment Carryforward Schedule

Cost Year		Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Totals
		Excess on Original CON	Excess on Original CON	Excess on Original CON	2000 Heritage Furn Adj #1	2000 Heritage Furn Adj #2	2000 Heritage Furn Adj #3	2000 Heritage Furn Adj #3	2000 Heritage Furn Adj #4	2000 Heritage Furn Adj #5	2000 Heritage Furn Adj #6	2000 Heritage Furn Adj #7	1996 Computer Adj	1996 Chair Mate & Bed	Bed Addition Adj	2007 Heritage Furn Profit	2008 Heritage Furn Profit	2008 Heritage Furn Profit	2009 Heritage Furn Profit	
	Cost	$ 47,990	$ 9,851	$ 11,448	$ 521	$ 47	$ 480	$ 275	$ 547	$ 949	$ 475	$ 203	$ 2,364	$ 1,819	$ 151,274	$ 25,011	$ 533	$ 8,573	$ 860	$ 263,220
	Term	$ 30	$ 7	$ 5	$ 10	$ 15	$ 10	$ 5	$ 7	$ 10	$ 10	$ 15	$ 5	$ 15	$ 19	$ 10	$ 5	$ 10	$ 5	
1994	Deprec	$ 800	$ 704	$ 1,145																$ 2,649
1994	Book Value	$ 47,191	$ 9,147	$ 10,303																$ 66,641
1995	Deprec	$ 1,600	$ 1,407	$ 2,290																$ 5,297
1995	Book Value	$ 45,591	$ 7,740	$ 8,013																$ 61,344
1996	Deprec	$ 1,600	$ 1,407	$ 2,290									$ 236	$ 61						$ 5,594
1996	Book Value	$ 43,991	$ 6,333	$ 5,724									$ 2,128	$ 1,758						$ 59,934
1997	Deprec	$ 1,600	$ 1,407	$ 2,290	$ 52	$ 3							$ 473	$ 121						$ 5,946
1997	Book Value	$ 42,391	$ 4,925	$ 3,434	$ 469	$ 44							$ 1,655	$ 1,637						$ 54,555
1998	Deprec	$ 1,600	$ 1,407	$ 2,290	$ 52	$ 3	$ 48						$ 473	$ 121	$ 7,916					$ 13,910
1998	Book Value	$ 40,792	$ 3,518	$ 1,145	$ 417	$ 41	$ 432						$ 1,182	$ 1,516	$ 143,358					$ 192,401
1999	Deprec	$ 1,600	$ 1,407	$ 1,145	$ 52	$ 3	$ 48	$ 55	$ 78	$ 95			$ 473	$ 121	$ 7,916					$ 12,993
1999	Book Value	$ 39,192	$ 2,111	$ -	$ 365	$ 37	$ 384	$ 220	$ 469	$ 854			$ 709	$ 1,395	$ 135,442					$ 181,178
2000	Deprec	$ 1,600	$ 1,407		$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14	$ 473	$ 121	$ 7,916					$ 11,910
2000	Book Value	$ 37,592	$ 704		$ 313	$ 34	$ 336	$ 165	$ 391	$ 759	$ 427	$ 189	$ 236	$ 1,274	$ 127,526					$ 169,946
2001	Deprec	$ 1,600	$ 704		$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14	$ 236	$ 121	$ 7,916					$ 10,970
2001	Book Value	$ 35,993	$ -		$ 260	$ 31	$ 288	$ 110	$ 313	$ 664	$ 380	$ 176	$ -	$ 1,153	$ 119,610					$ 158,978
2002	Deprec	$ 1,600			$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 10,030
2002	Book Value	$ 34,393			$ 208	$ 28	$ 240	$ 55	$ 234	$ 569	$ 332	$ 162		$ 1,032	$ 111,694					$ 148,947
2003	Deprec	$ 1,600			$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 10,030
2003	Book Value	$ 32,793			$ 156	$ 25	$ 192	$ -	$ 156	$ 474	$ 285	$ 149		$ 911	$ 103,778					$ 138,919
2004	Deprec	$ 1,600			$ 52	$ 3	$ 48		$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 9,975
2004	Book Value	$ 31,194			$ 104	$ 22	$ 144		$ 78	$ 379	$ 237	$ 135		$ 790	$ 95,862					$ 128,945
2005	Deprec	$ 1,600			$ 52	$ 3	$ 48		$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 9,975
2005	Book Value	$ 29,594			$ 52	$ 19	$ 96		$ -	$ 285	$ 190	$ 122		$ 669	$ 87,946					$ 118,973
2006	Deprec	$ 1,600			$ 52	$ 3	$ 48			$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 9,897
2006	Book Value	$ 27,994			$ -	$ 16	$ 48			$ 190	$ 142	$ 108		$ 548	$ 80,030					$ 109,076
2007	Deprec	$ 1,600				$ 3	$ 48			$ 95	$ 48	$ 14		$ 121	$ 7,916	$ 1,251				$ 11,096
2007	Book Value	$ 26,395				$ 12	$ -			$ 95	$ 95	$ 95		$ 427	$ 72,114	$ 23,760				$ 122,993
2008	Deprec	$ 1,600				$ 3				$ 95	$ 48	$ 14		$ 121	$ 7,916	$ 2,501	$ 53	$ 429		$ 12,780
2008	Book Value	$ 24,795				$ 9				$ -	$ 48	$ 81		$ 306	$ 64,198	$ 21,259	$ 480	$ 8,144		$ 119,320
2009	Deprec	$ 1,600				$ 3					$ 48	$ 14		$ 121	$ 7,916	$ 2,501	$ 107	$ 857	$ 86	$ 13,253
2009	Book Value	$ 23,195				$ 6					$ -	$ 68		$ 185	$ 56,282	$ 18,758	$ 373	$ 7,287	$ 774	$ 106,928
2010	Deprec	$ 1,600				$ 3						$ 14		$ 121	$ 7,916	$ 2,501	$ 107	$ 857	$ 172	$ 13,291
2010	Book Value	$ 21,596				$ 3						$ 54		$ 64	$ 48,366	$ 16,257	$ 266	$ 6,430	$ 602	$ 93,638
2011	Deprec	$ 1,600				$ 3						$ 14		$ 64	$ 7,916	$ 2,501	$ 107	$ 857	$ 172	$ 13,234
2011	Book Value	$ 19,996				$ -						$ 41		$ -	$ 40,450	$ 13,756	$ 159	$ 5,573	$ 430	$ 80,405
2012	Deprec	$ 1,600										$ 14			$ 7,916	$ 2,501	$ 107	$ 857	$ 172	$ 13,167
2012	Book Value	$ 18,396										$ 27			$ 32,534	$ 11,255	$ 52	$ 4,716	$ 258	$ 67,238
2013	Deprec	$ 1,600										$ 14			$ 7,916	$ 2,501	$ 52	$ 857	$ 172	$ 13,112
2013	Book Value	$ 16,797										$ 14			$ 24,618	$ 8,754	$ -	$ 3,859	$ 86	$ 54,128
2014	Deprec	$ 1,600										$ 14			$ 7,916	$ 2,501		$ 857	$ 86	$ 12,974
2014	Book Value	$ 15,197										$ -			$ 16,702	$ 6,253		$ 3,002	$ -	$ 41,154
2015	Deprec	$ 1,600													$ 7,916	$ 2,501		$ 857		$ 12,874
2015	Book Value	$ 13,597													$ 8,786	$ 3,752		$ 2,145		$ 28,280
2016	Deprec	$ 1,600													$ 7,916	$ 2,501		$ 857		$ 12,874
2016	Book Value	$ 11,998													$ 870	$ 1,251		$ 1,288		$ 15,407
2017	Deprec	$ 1,600													$ 870	$ 1,251		$ 857		$ 4,578
2017	Book Value	$ 10,398													$ -	$ -		$ 431		$ 10,829
2018	Deprec	$ 1,600																$ 431		$ 2,031
2018	Book Value	$ 8,798																$ -		$ 8,798
2019	Deprec	$ 1,600																		$ 1,600
2019	Book Value	$ 7,199																		$ 7,199
2020	Deprec	$ 1,600																		$ 1,600
2020	Book Value	$ 5,599																		$ 5,599
2021	Deprec	$ 1,600																		$ 1,600
2021	Book Value	$ 3,999																		$ 3,999
2022	Deprec	$ 1,600																		$ 1,600
2022	Book Value	$ 2,400																		$ 2,400
2023	Deprec	$ 1,600																		$ 1,600
2023	Book Value	$ 800																		$ 800
2024	Deprec	$ 800																		$ 800
2024	Book Value	$ -																		$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	17,171,615	17,171,615		
b. Medicaid Room and Board Contractual Allowance **	$	(9,069,807)	(9,069,807)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	1,887,434	1,887,434		
b. Medicare Room and Board Contractual Allowance **	$	439,612	439,612		
4. a. Private-Pay Residents and Other	$	3,617,144	3,617,144		
b. Private-Pay Room and Board Contractual Allowance **	$	(495,258)	(495,258)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	198,317	198,317		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(198,317)	(198,317)		
c. Prescription Drugs - Non-Medicare	$	133,444	133,444		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(92,161)	(92,161)		
2. a. Medical Supplies - Medicare	$	5,580	5,580		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	128	128		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(128)	(128)		
3. a. Physical Therapy - Medicare	$	740,365	740,365		
b. Physical Therapy - Medicare Contractual Allowance **	$	(564,571)	(564,571)		
c. Physical Therapy - Non-Medicare	$	269,041	269,041		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(269,041)	(269,041)		
4. a. Speech Therapy - Medicare	$	226,793	226,793		
b. Speech Therapy - Medicare Contractual Allowance **	$	(174,661)	(174,661)		
c. Speech Therapy - Non-Medicare	$	58,270	58,270		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(58,270)	(58,270)		
5. a. Occupational Therapy - Medicare	$	895,710	895,710		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(626,716)	(626,716)		
c. Occupational Therapy - Non-Medicare	$	250,225	250,225		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(250,225)	(250,225)		
6. a. Other (*Specify*) - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	4,248	4,248		
III *Total Resident Revenue* (Section I.thru Section II.)	$	14,098,771	14,098,771		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	174	174		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	400	400		
V. Total Other Revenue (1 thru 8)	$	574	574		
VI. Total All Revenue (III + V)	$	14,099,345	14,099,345		

* *Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.*

** *Facility should report all contractual allowances and/or payer discounts..*

Schedule of Other Resident Revenue - Medicare

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	$ 4,248		
Total Other Resident Revenue		$ 4,248	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	N/A	$ 174		
Total Interest Income			$ 174	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	$ 400		
Total Other Revenue		$ 400	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 313,542
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 933,119
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 29,952
5. Prepaid Expenses			$ 137,164
a. Prepaid Insurance		133,664	
b. Landlord Audit Fee		3,500	
c.			
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 225,460
Due From Related Parties		200,546	
Medicaid Cost Settlement		24,914	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 1,639,237
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost	70,380	$ 11,363
	Accum. Depreciation	(59,017) Net	
3. Buildings	*Historical Cost	2,747,856	$ 926,008
	Accum. Depreciation	(1,821,848) Net	
4. Leasehold Improvements	*Historical Cost	62,006	$ 52,679
	Accum. Depreciation	(9,327) Net	
5. Non-Movable Equipment	*Historical Cost	630,911	$ 397,081
	Accum. Depreciation	(233,830) Net	
6. Movable Equipment	*Historical Cost	902,075	$ 165,624
	Accum. Depreciation	(736,451) Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 15,407
Excluded Movable Equipment		15,407	
		-	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 1,568,162

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

(*Carry Total forward to next page*)

SHADY KNOLL HEALTH CENTER
Prepaid Expenses
September 30, 2016

	ACCT. # 1580	
DHLS LL Audit invoice paid by SNF - LL to reimburse SNF in FY17	3,500.00	5126
G/L BALANCE at 9/30/16	3,500.00	

Shady Knoll Moveable Equipment Carryforward Schedule

Cost Year		Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Totals
		Excess on Original CON	Excess on Original CON	Excess on Original CON	2000 Heritage Furn Adj #1	2000 Heritage Furn Adj #2	2000 Heritage Furn Adj #3	2000 Heritage Furn Adj #3	2000 Heritage Furn Adj #4	2000 Heritage Furn Adj #5	2000 Heritage Furn Adj #6	2000 Heritage Furn Adj #7	1996 Computer Adj	1996 Chair Mate & Bed	Bed Addition Adj	2007 Heritage Furn Profit	2008 Heritage Furn Profit	2008 Heritage Furn Profit	2009 Heritage Furn Profit	
	Cost	$ 47,990	$ 9,851	$ 11,448	$ 521	$ 47	$ 480	$ 275	$ 547	$ 949	$ 475	$ 203	$ 2,364	$ 1,819	$ 151,274	$ 25,011	$ 533	$ 8,573	$ 860	$ 263,220
	Term	$ 30	$ 7	$ 5	$ 10	$ 15	$ 10	$ 5	$ 7	$ 10	$ 10	$ 15	$ 5	$ 15	$ 19	$ 10	$ 5	$ 10	$ 5	
1994	Deprec	$ 800	$ 704	$ 1,145																$ 2,649
1994	Book Value	$ 47,191	$ 9,147	$ 10,303																$ 66,641
1995	Deprec	$ 1,600	$ 1,407	$ 2,290																$ 5,297
1995	Book Value	$ 45,591	$ 7,740	$ 8,013																$ 61,344
1996	Deprec	$ 1,600	$ 1,407	$ 2,290									$ 236	$ 61						$ 5,594
1996	Book Value	$ 43,991	$ 6,333	$ 5,724									$ 2,128	$ 1,758						$ 59,934
1997	Deprec	$ 1,600	$ 1,407	$ 2,290	$ 52	$ 3							$ 473	$ 121						$ 5,946
1997	Book Value	$ 42,391	$ 4,925	$ 3,434	$ 469	$ 44							$ 1,655	$ 1,637						$ 54,555
1998	Deprec	$ 1,600	$ 1,407	$ 2,290	$ 52	$ 3	$ 48						$ 473	$ 121	$ 7,916					$ 13,910
1998	Book Value	$ 40,792	$ 3,518	$ 1,145	$ 417	$ 41	$ 432						$ 1,182	$ 1,516	$ 143,358					$ 192,401
1999	Deprec	$ 1,600	$ 1,407	$ 1,145	$ 52	$ 3	$ 48	$ 55	$ 78	$ 95			$ 473	$ 121	$ 7,916					$ 12,993
1999	Book Value	$ 39,192	$ 2,111	$ -	$ 365	$ 37	$ 384	$ 220	$ 469	$ 854			$ 709	$ 1,395	$ 135,442					$ 181,178
2000	Deprec	$ 1,600	$ 1,407		$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14	$ 473	$ 121	$ 7,916					$ 11,910
2000	Book Value	$ 37,592	$ 704		$ 313	$ 34	$ 336	$ 165	$ 391	$ 759	$ 427	$ 189	$ 236	$ 1,274	$ 127,526					$ 169,946
2001	Deprec	$ 1,600	$ 704		$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14	$ 236	$ 121	$ 7,916					$ 10,970
2001	Book Value	$ 35,993	$ -		$ 260	$ 31	$ 288	$ 110	$ 313	$ 664	$ 380	$ 176	$ -	$ 1,153	$ 119,610					$ 158,978
2002	Deprec	$ 1,600			$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 10,030
2002	Book Value	$ 34,393			$ 208	$ 28	$ 240	$ 55	$ 234	$ 569	$ 332	$ 162		$ 1,032	$ 111,694					$ 148,947
2003	Deprec	$ 1,600			$ 52	$ 3	$ 48	$ 55	$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 10,030
2003	Book Value	$ 32,793			$ 156	$ 25	$ 192	$ -	$ 156	$ 474	$ 285	$ 149		$ 911	$ 103,778					$ 138,919
2004	Deprec	$ 1,600			$ 52	$ 3	$ 48		$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 9,975
2004	Book Value	$ 31,194			$ 104	$ 22	$ 144		$ 78	$ 379	$ 237	$ 135		$ 790	$ 95,862					$ 128,945
2005	Deprec	$ 1,600			$ 52	$ 3	$ 48		$ 78	$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 9,975
2005	Book Value	$ 29,594			$ 52	$ 19	$ 96		$ -	$ 285	$ 190	$ 122		$ 669	$ 87,946					$ 118,973
2006	Deprec	$ 1,600			$ 52	$ 3	$ 48			$ 95	$ 48	$ 14		$ 121	$ 7,916					$ 9,897
2006	Book Value	$ 27,994			$ -	$ 16	$ 48			$ 190	$ 142	$ 108		$ 548	$ 80,030					$ 109,076
2007	Deprec	$ 1,600				$ 3	$ 48			$ 95	$ 48	$ 14		$ 121	$ 7,916	$ 1,251				$ 11,096
2007	Book Value	$ 26,395				$ 12	$ -			$ 95	$ 95	$ 95		$ 427	$ 72,114	$ 23,760				$ 122,993
2008	Deprec	$ 1,600				$ 3				$ 95	$ 48	$ 14		$ 121	$ 7,916	$ 2,501	$ 53	$ 429		$ 12,780
2008	Book Value	$ 24,795				$ 9				$ -	$ 48	$ 81		$ 306	$ 64,198	$ 21,259	$ 480	$ 8,144		$ 119,320
2009	Deprec	$ 1,600				$ 3					$ 48	$ 14		$ 121	$ 7,916	$ 2,501	$ 107	$ 857	$ 86	$ 13,253
2009	Book Value	$ 23,195				$ 6					$ -	$ 68		$ 185	$ 56,282	$ 18,758	$ 373	$ 7,287	$ 774	$ 106,928
2010	Deprec	$ 1,600				$ 3						$ 14		$ 121	$ 7,916	$ 2,501	$ 107	$ 857	$ 172	$ 13,291
2010	Book Value	$ 21,596				$ 3						$ 54		$ 64	$ 48,366	$ 16,257	$ 266	$ 6,430	$ 602	$ 93,638
2011	Deprec	$ 1,600				$ 3						$ 14		$ 64	$ 7,916	$ 2,501	$ 107	$ 857	$ 172	$ 13,234
2011	Book Value	$ 19,996				$ -						$ 41		$ -	$ 40,450	$ 13,756	$ 159	$ 5,573	$ 430	$ 80,405
2012	Deprec	$ 1,600										$ 14			$ 7,916	$ 2,501	$ 107	$ 857	$ 172	$ 13,167
2012	Book Value	$ 18,396										$ 27			$ 32,534	$ 11,255	$ 52	$ 4,716	$ 258	$ 67,238
2013	Deprec	$ 1,600										$ 14			$ 7,916	$ 2,501	$ 52	$ 857	$ 172	$ 13,112
2013	Book Value	$ 16,797										$ 14			$ 24,618	$ 8,754	$ -	$ 3,859	$ 86	$ 54,128
2014	Deprec	$ 1,600										$ 14			$ 7,916	$ 2,501		$ 857	$ 86	$ 12,974
2014	Book Value	$ 15,197										$ -			$ 16,702	$ 6,253		$ 3,002	$ -	$ 41,154
2015	Deprec	$ 1,600													$ 7,916	$ 2,501		$ 857		$ 12,874
2015	Book Value	$ 13,597													$ 8,786	$ 3,752		$ 2,145		$ 28,280
2016	Deprec	$ 1,600													$ 7,916	$ 2,501		$ 857		$ 12,874
2016	Book Value	$ 11,998													$ 870	$ 1,251		$ 1,288		$ 15,407
2017	Deprec	$ 1,600													$ 870	$ 1,251		$ 857		$ 4,578
2017	Book Value	$ 10,398													$ -	$ -		$ 431		$ 10,829
2018	Deprec	$ 1,600																$ 431		$ 2,031
2018	Book Value	$ 8,798																$ -		$ 8,798
2019	Deprec	$ 1,600																		$ 1,600
2019	Book Value	$ 7,199																		$ 7,199
2020	Deprec	$ 1,600																		$ 1,600
2020	Book Value	$ 5,599																		$ 5,599
2021	Deprec	$ 1,600																		$ 1,600
2021	Book Value	$ 3,999																		$ 3,999
2022	Deprec	$ 1,600																		$ 1,600
2022	Book Value	$ 2,400																		$ 2,400
2023	Deprec	$ 1,600																		$ 1,600
2023	Book Value	$ 800																		$ 800
2024	Deprec	$ 800																		$ 800
2024	Book Value	$ -																		$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	32	37

	Account			Amount
			Total Brought Forward:	$ 3,207,399
C.	Leasehold or like property recorded for Equity Purposes.			
	1. Land			$ 649,355
	2. Land Improvements	*Historical Cost.....		
		Accum. Depreciation	Net.....	$
	3. Buildings	*Historical Cost.....	5,602,448	
		Accum. Depreciation	(4,341,605) Net.....	$ 1,260,843
	4. Non-Movable Equipment	*Historical Cost.....		
		Accum. Depreciation	Net.....	$
	5. Movable Equipment	*Historical Cost.....		
		Accum. Depreciation	Net.....	$
	6. Motor Vehicles	*Historical Cost.....		
		Accum. Depreciation	Net.....	$
	7. Minor Equipment-Not Depreciable			$
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)			$ 1,910,198
D.	Investment and Other Assets			
	1. Deferred Deposits			$
	2. Escrow Deposits			$
	3. Organization Expense	*Historical Cost.....		
		Accum. Depreciation	Net.....	$
	4. Goodwill (Purchased Only)			$ 711,189
	5. Investments Related to Resident Care (*itemize*)			$
	6. Loans to Owners or Related Parties (*itemize*)			$ (18,180,047)
	Name and Address	Amount	Loan Date	
	Related Party Facilities	(18,180,047)	3/29/2012	
	7. Other Assets (*itemize*)			$ 95,017
	Desposits-Taxes		60,517	
	Deposits-Lease		14,192	
	Project Development		20,308	
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ (17,373,841)
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ (12,256,244)

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	33	37

Account		Amount
Liabilities		
A. Current Liabilities		
1. Trade Accounts Payable		$ 905,092
2. Notes Payable (*itemize*)		$ 1,905,845
Loans	1,905,845	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)		$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)		$ 373,698
5. Accrued Payroll (*Owners and/or Stockholders only*)		$
6. Accrued Payroll Taxes Payable		$ 15,373
7. Medicare Final Settlement Payable		$
8. Medicare Current Financing Payable		$
9. Mortgage Payable (*Current Portion*)		$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)		$ 6,894
11. Accrued Income Taxes*		$
12. Other Current Liabilities (*itemize*)		$ 262,283
Acc'd Operating Expenses	52,109	
Acc'd Expense - CT Sales & Use Tax	645	
Provider Taxes Due	212,408	
Acc'd Expense-Personal Property Tax	(2,879)	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)		$ 3,469,185

* Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

SHADY KNOLL HEALTH CENTER
ACCRUED EXPENSES - OPERATING
September 30, 2016

ACCT. # 2170

Wage Enhancement	9,000.00	
9/30/16 Audit Fee	$14,000.00	
Health Insurance	$536.40	
Leaf - property tax	($152.15)	reversed out - recorded in Aug already
Pitney Bowes Lease 10/10/16-1/9/17	($865.26)	invoice relates to FY17
Food Rebate - Athena	($1,533.32)	Not received in AR by Sept 30
Athena Mgmt Fee Adj - Sept 2016	($200.51)	
Griffin Hospital Sept	$5,563.67	
ProCare Sept	$24,432.42	
Afco Cyber/Internet - Athena HCS	$1,328.20	
	$52,109.45	**9/30/2016**

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	34	37

Account	Amount
Total Brought Forward:	3,469,185
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 209,785

Name of Lender	Purpose	Amount	Date Due
Graybar Financial Services	**Boiler/Solar Panel**	**209,785**	**05/31/19**

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ (9,354,348)

Name and Address of Lender	Amount	Loan Date
Related Party	**(9,354,348)**	**03/29/12**

4. Other Long-Term Liabilities (*itemize*)		$ (1,739,556)
N/P L/T Related Party Landlord	**(2,367,720)**	
Key Bank Term Loan	**612,105**	
Deferred Energy Credit	**16,059**	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (10,884,119)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ (7,414,934)

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G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 649,355
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$ 1,260,843
	3. Reserve for depreciation value of leased personal property (*Equity*) ..	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 1,910,198
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (7,036,694)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ 284,186
	7. Total Net Worth	$ (6,751,508)
C.	***Total Reserves and Net Worth***	$ (4,841,310)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (12,256,244)

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (7,029,358)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,099,345
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 13,815,159
D.	Net Income or Deficit			$ 284,186
E.	Balance			$ (6,745,172)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
			(20,048)	
	SWAP Change		**13,712**	
	2. Other (*itemize*)			
F-3.	Total Additions			$ (6,336)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings (Specify)			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/16		$ (6,751,508)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	**2107C**	**9/30/2016**	37	37

Check appropriate category		
CCNH	RHNS	Other (*Specify*)
☑	☐	☐

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the appplicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
	CFO	2-15-17

Printed Name of Preparer

Athena Health Care Associates, Inc

Address	Phone Number
135 South Road Farmington, CT 06032	(860) 751-3900

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.